

Welcome to the UW Spine Clinic

You are scheduled on _____ to see _____.

In order to best serve your needs, please bring with you the following to your appointment:

1. Completed Questionnaire (questionnaire enclosed)

2. Spinal Imaging

Hand-carry any plain x-rays, MRI scans, CT scans, etc. that you may have had done at another facility. Radiology reports are not sufficient; we need the actual film and report. Typically, we require the x-rays to be 6 months old or less. If your insurance will not allow films to be done here, you may want to have new ones done at your clinic.

3. Medical Records

Please bring any previous spinal operative notes.

4. Insurance Referral (if needed)

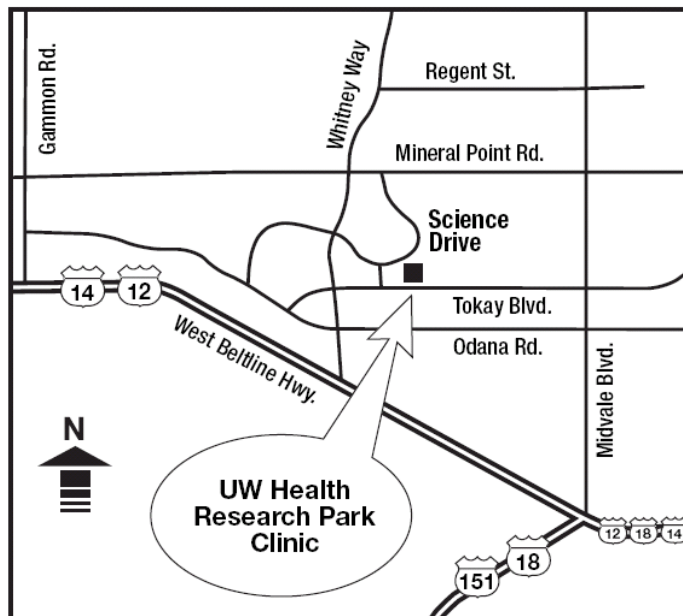
If you belong to an HMO, bring a copy of your referral with you. If this is a worker's compensation claim, bring the claim number, the name of the insurance company and the address where the claim should be sent.

If you have any questions regarding your upcoming appointment, please do not hesitate to give us a call at (608)265-3207. Our fax number is (608)263-4995.

Directions

The Spine Clinic is located at the UW Health Research Park Clinic, 621 Science Drive, Madison, Wisconsin. (608) 265-3207

- From the east – take Mineral Point Road west and turn left on Science Drive (before Whitney Way).
- From the west – take Mineral Point Road east, turn right on Whitney Way and left on Science Drive.
- From the beltline (12&18) – take Whitney Way exit north, go straight through intersections of Odana and Tokay and turn right on Science Drive.



Welcome to the UW Health Spine Clinic

To help you better prepare for your clinic visit with us, please review the following information. This comprehensive list outlines what to expect, as well as the health care providers you may encounter at a typical clinic visit. Your visit with us may or may not include all of the services listed below. Thank you again for choosing the UW Health Spine Clinic as your health care provider.

1. **Check-in and Waiting Area:** Please register at the entrance to the clinic building. Next, you will then take the elevators to the second floor and have a seat in the Spine Clinic lobby until we call you back to a room. If you are a new patient and have not filled out the patient health history questionnaire, please obtain one at the second floor information desk. 15-20 minutes average
2. **Electronic Medical Record Update:** A medical assistant (MA) will bring you from the waiting area and take you to your clinic room. The MA will then update your current medications and health status in your electronic medical record. 5-10 minutes average
3. **Preliminary Examination:** You will be seen by the physician's resident, physician assistant, nurse practitioner, or medical student who will note your history, perform a preliminary physical examination. A determination will be made to see if you need radiographic films. 15-20 minutes average
4. **Radiology:** If you need new x-ray films, you will be sent down the hall to radiology (you may be asked to change into shorts or a gown for x-rays). You will then return to your clinic room and your films will be sent electronically to your room; you do not need to hand carry any films. 10-30 minutes average
5. **Physician Evaluation & Assessment:** The physician will review your history and repeat essential parts of the physical examination. At the completion of this assessment, the physician will provide you with a diagnosis and a comprehensive treatment plan. 20 minutes average

This plan may include, but is not limited to, the following:

- **Prescription for Braces / Orthotics:** Depending on the type of orthotic prescribed, you may see the orthotic technician at your clinic visit, or you may be asked to schedule an appointment at a later date.
- **Consult for Spine Physical Therapy:** You may schedule a spine physical therapy appointment at any provider that is covered by your insurance.
- **Referral to other health care providers:** Contact information will be provided at your clinic visit. Appointments may potentially be scheduled at the Spine Clinic front desk, or you may be directed to schedule them on your own.
- **Follow-up Appointment:** An appointment sheet will be provided at the end of your visit which should be taken to the Spine Clinic front desk to schedule your next appointment.

****Please allow approximately two hours for your initial clinic visit****

Welcome to our clinic

Welcome!

Welcome to our clinic. Thank you for the opportunity to be a partner in your health care. At UW Health we strive to provide the best possible care. Our clinic is part of the University of Wisconsin. In addition to your physician, nurse practitioner or physician assistant, you may be seen by a resident physician, medical student or advanced practice nursing student.

Telephone Availability

Feel free to call any time you have concerns about your health. If you call the clinic before 4 p.m. we will make every effort to respond that day. If your call is urgent, we will review your needs and arrange for care.

To respect your privacy, we will not leave information on answering machines or share information regarding patients over the age of 18 without their permission.

After Hours Care

In the event of an emergency, call 911. For urgent questions or concerns, please call (608) 262-2122. You will be connected to the answering service. They will contact the physician on call. Our doctors admit patients to UW Hospital.

Prescriptions

Before you run out of a prescribed medication, you can renew as follows:

1. Ask your doctor during your appointment.
2. Call your pharmacy, who will contact your doctor for you.

Please contact your pharmacy at least 48 hours before your medication runs out. Chronic narcotic patients should call the clinic one week before your medication runs out.

Lab Work/Tests

You will be contacted with your test results within 14 days unless your doctor tells you otherwise. If you have not received your test results after two weeks, please call the clinic at (608) 265-3207.

Appointments - Outpatient Attendance

Please schedule your return appointment before leaving. If you have questions or concerns before your next scheduled appointment, don't hesitate to call the clinic. If you have changes in your medication, allergies or current health, please share with your provider at your next scheduled appointment. If you need to cancel an appointment, please call us as soon as possible. This allows us to meet the needs of other patients.

Please contact our registration department at (608) 262-1400 with any changes of address or insurance. We require verification of information through registration every 120 days. Contacting our registration department before your appointment will prevent delays.

Resources

Question/Concern	Resource	Contact Information
Insurance	Please call your insurance company to verify coverage for therapy services.	
Billing	Patient Billing Service	(608) 262-2221 or (866) 841-8535
Pricing	Priceline	(608) 263-1507
Financial Hardship	Community Care Line	(608) 262-2221 or (866) 841-8535
Other Questions	Patient Relations	(608) 263-8009
On-Line prescription renewal	Pharmacy	uwhealth.org/rx

Patient Name: _____

DOB: _____

MR #: _____

Date: _____

University of Wisconsin Hospital and Clinics

600 Highland Avenue • Madison, Wisconsin 53792

INITIAL PATIENT QUESTIONNAIRE – SPINE

(BRING THIS QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT. DO NOT MAIL)

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below: PAIN = XXXXXX NUMBNESS = OOOOOO

FRONT

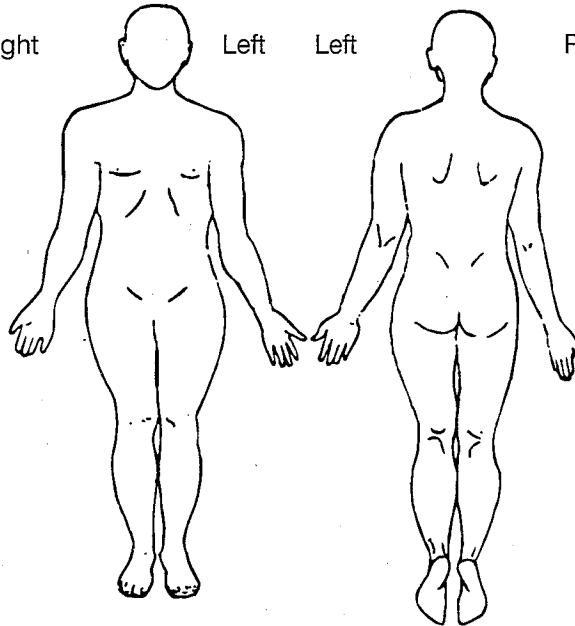
BACK

Right

Left

Left

Right



If more than one area, which is worse? _____

How long have you had this problem? _____

Did your symptoms follow an injury? _____ If yes; _____ at work _____ auto accident _____ other

Describe: _____

Circle your least and greatest pain levels over the past two weeks:

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Have you had neck/back symptoms before? Y___ N___

Have you ever had previous back or neck surgery? Y___ N___

If yes, describe: _____

Is the purpose of this exam to determine disability status for the government or an insurance agency? _____

Are you currently receiving any type of financial compensation for your back problem? _____

Do you have an attorney for your back problem? _____

Patient Name:

DOB:

MR #:

Please list previous radiology studies you have had for this problem.

Date

Location

MRI _____

CT Scan _____

Myelogram _____

Bone Scan _____

EMG _____

X-rays _____

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for you back/neck in the past. Then check the column that best describes the effect of the treatment.

<u>Treatment</u>	Check if you have had this	Did it make things		
		<u>Better</u>	<u>Worse</u>	<u>No change</u>
Hot packs/ice	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
TENS/E-Stim	_____	_____	_____	_____
Yoga/Tai-Chi	_____	_____	_____	_____
Exercises	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Bed Rest	_____	_____	_____	_____
Pool therapy	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Injections	_____	_____	_____	_____
Braces/Splints	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Chiropractic Adjustments	_____	_____	_____	_____

MEDICAL HISTORY:

Have you ever had:

- | | | | |
|----------------------------------------|------------------------------|-------------------|----------------------|
| ___ AIDS or HIV testing | ___ Phlebitis or blood clots | ___ Kidney Stones | ___ GERD |
| ___ Asthma/Breathing problems | ___ Stroke | ___ Arthritis | ___ High Cholesterol |
| ___ Cancer | ___ Thyroid trouble | ___ Seizures | |
| ___ Radiation/Chemotherapy | ___ Kidney Infections | ___ Ulcer | |
| ___ Migraine or other severe head pain | ___ Heart Disease | ___ Tuberculosis | |
| ___ High Blood Pressure | ___ Diabetes | ___ Hepatitis | |
| ___ Chronic Fatigue Syndrome | ___ Fibromyalgia | ___ Other: _____ | |

Patient Name:

DOB:

MR #:

REVIEW OF SYSTEMS:

Check all that apply.

Constitutional

Fever____
Chills____
Night sweats____
Weight loss____
Loss of appetite____

Allergy/immune

Drug allergy____
Seasonal allergy____
Food allergy____
Iodine allergy____
Transplant____

Neurologic

Paralysis____
Tremors____
Spasticity____
Seizures____
Muscle atrophy____
Double vision____

Musculoskeletal

Joint stiffness/swelling____
Muscle pain/swelling____
Fatigue____
Fractures____

Hemolymphatic

Anemia____
Excessive bleeding____
Easy bruising____
Lymphoma____
Leukemia____
Cancer____
Lymph node swelling____

CV/Respiratory

Shortness of breath____
Wheezing____
Cough____
Coughing up blood____
Chest pains____
Palpitations____
Leg swelling____

Gastrointestinal

Difficulty swallowing____
Heartburn____
Nausea/vomiting____
Constipation____
Diarrhea____
Blood in stools____
Stomach pain____

Endocrine

Obesity____
Thyroid disorder____
Diabetes____
Menopause____
Menstrual irregularities____
Pelvic Pain____
Addison's disease____

HEENT

Loss of vision____
Eye Redness____
Headaches____
Dizziness____
Glaucoma____

Skin/integumentary

Rash____
Ulcer____
Eczema____
Hives____
Sexual Difficulties____

Genitourinary

Pain urinating____
Incontinence____
Blood in urine____
Dribbling____
Pregnant____
Last Menstrual Period (date)____

Psychiatric

Poor sleep____
Depression____
Anxiety____
Stress at work/home____

PAST SURGICAL HISTORY:

Year	Operation	Place Hospitalized

ALLERGIES:

Name of medicine/substance	Type of reaction	Date

Patient Name: _____

DOB: _____

MR #: _____

MEDICINES: List all medicines that you take, including the doses and how often you take them. Include vitamins and nonprescription medicine.

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY:

Spinal Problems Y__ N__ If yes, describe: _____
Bleeding Disorders Y__ N__ If yes, describe: _____
Heart Disease Y__ N__ If yes, describe: _____
Cancer Y__ N__ If yes, describe: _____
Diabetes Y__ N__ If yes, describe: _____

SOCIAL HISTORY:

How many years of schooling? (circle one)

Less than high school high school graduate technical school diploma 1-3 years of college
College graduate post graduate or professional degree

Marital Status: Single__ Married__ Divorced__ Remarried__ Widowed__ Separated__

Who lives with you at home? _____

Work status: Working__ Not Working__ Student__ Disabled__ Retired__

Primary Occupation: _____ Employer: _____

How long have you worked at your present job? _____ If not working, last date worked: _____

Have you ever smoked? _____ Type/Amount: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day? _____

Have you used: Marijuana _____ Cocaine _____ Heroin _____ Other _____

Do you get any regular exercise? Describe: _____

Completed by: _____ Date: _____
If not completed by patient, relationship to patient: _____
Reviewed by: _____ Date: _____ Time: _____